CHILD DEATH REVIEW TEAM REPORT

to the

GOVERNOR'S CHILDREN'S TASK FORCE

November 18, 2003

Submitted by:

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CHILD DEATH REVIEW TEAM

Introduction

Children are not supposed to die. The death of a child is a singularly tragic event. Especially tragic is a child death that could and should have been prevented. Each year, approximately 300 children die in Nebraska. The Nebraska Legislature passed legislation in 1993 creating the State Child Death Review Team (CDRT) which is responsible for reviewing all child deaths that occur in Nebraska. Although child death review teams around the country were established originally to identify and prevent child deaths caused by abuse and neglect, Nebraska has opted for a broader death review process that addresses all child deaths from a public health perspective. This public health approach not only addresses the under-reporting of maltreatment-related deaths, but promotes better understanding and greater awareness of all the causes of child deaths. The focus of the CDRT's work is:

- Better understanding of why our children die.
- Accurate identification and uniform reporting of the cause and manner of every child death.
- Identification of needed changes in legislation, policy and practices; and expanded efforts in child health and safety to prevent child deaths.

Nebraska's CDRT is comprised of twelve members including prosecuting attorneys, physicians, mental health and public health professionals, law enforcement, advocates, statisticians, a forensic pathologist and child protective service personnel. Joann Schaefer, M.D. serves as chair of the CDRT and Debora Barnes-Josiah, Ph.D. provides staff support. Members of the CDRT are appointed by the Director of the Department of Health and Human Services.

At the request of the Children's Task Force, a subcommittee of the CDRT reviewed 30 child deaths due to child abuse that occurred in Nebraska between 1998 and November 2003. Members of the subcommittee included: Karen Authier, Jerry Watson, Herb Spears, Debora Barnes-Josiah, Mary Jo Pankoke and Todd Reckling. Stacie Bleicher, M.D., Gary Lacey, and Suzanne Schied provided additional expertise. The CDRT was asked by the Task Force Steering Committee to focus its review on deaths resulting from a violent act by the parent or other caretaker. Only one death resulting from neglect is represented in the cases reviewed. The 30 cases that were selected for review included 21 that were brought to Governor Johanns' attention and which led to the creation of the Children's Task Force. The CDRT identified nine additional cases for review that involved deaths due to abuse by a caretaker that have occurred since 2000.

All 30 of the child death cases were reviewed by at least two CDRT members and were discussed by the subcommittee as a group. Materials used in the review included law enforcement reports, child protective service records, hospital and medical records, public assistance records, criminal histories, and other relevant information from service providers. Because of pending criminal action, only limited law enforcement information was available on some cases.

The death of a child is a community problem and the circumstances involved in most child abuse deaths are too multidimensional for responsibility to rest in any one place. In thinking about what can be done to prevent child deaths, one must consider action that can be taken at multiple levels, such as what the immediate and extended family can do, what neighbors can do, what churches can do, what neighborhood organizations can do, what community agencies can do, etc. The findings and recommendations contained in this report are based on the group's analysis of issues and factors that contributed to the deaths and actions that could be taken to prevent future deaths.

Victim/Perpetrator Data

This report reflects information about 30 child victims of abuse and neglect that resulted in the death of the child. In most cases, one individual was directly responsible for the act that caused the child's death. However, in four cases both the mother of the child, and the father (2 cases) or mother's boyfriend (2 cases) were found, or alleged to be, equally responsible for the child's death. In two families, two children died in the same incident. Twenty-eight families are represented in these cases.

Several cases reviewed had unique circumstances. In one case, the youth died in an accident while in the company of other minors or young adults. While there are lessons to be learned from this situation, there were no perpetrators in the sense that there were in the other cases. Thus, information about this case is not included in the aggregate data on perpetrators. In another situation, the perpetrator has not yet been identified. In a third case, the child's death was ruled accidental and information about individuals involved also is not reflected in the perpetrator data.

Child Victims

Victim gender was almost evenly divided with 17 of the 30 (57%) male and 13 (43%) being female. Available data nationwide also shows minimal gender differences among children who die of child maltreatment.

Table 1: Victim Gender

Gender	Number
Male	17
Female	13

Victims ranged in age from 2 months to 13 years old in the cases reviewed. Nine of the 30 children, (30%) were under the age of one year. Eight of the victims (27%) were two years old. This figure would be consistent with the fact that infant crying and toilet training problems were often precipitating events for fatal injuries. A total of 25 children, (83%) were under the age of 5.

Table 2: Victim Age

Age (in Years)	Number
< 1	9
1	2
2	8
3	4
4	2
5	0
6-10	1
11-13	4
Total	**30**

Nebraska data reflect national data that indicate 76% of child death victims as a result of abuse and neglect are under the age of 5. Contributing factors include vulnerability due to the small size of the child, lack of verbal skills and limited contact outside of the family.

Table 3: Race of Victim

Race	Number
White	16
Black	9
Hispanic/White	5
Total	**30**

Race was determined from information entered on the death certificate or from law enforcement documents. Of the 30 children who died, 16 (53%) were identified as White. Five (17%) were identified as Hispanic/White, and 9 (30%) were identified as Black.

Identified Perpetrators

For purposes of this report, a perpetrator is defined as any individual who had direct responsibility for the death of the child, as determined by criminal charges being brought against that individual. In addition to the 29 people facing or having faced criminal charges, 11 mothers and 5 fathers have been brought into Juvenile Court in the interest of their surviving children.

Table 4: Perpetrator Gender

Gender	Number
Male	19
Female	10
Total	**29**

Of the 29 identified perpetrators, 19 (65%) were males, and 10 (35%) were females. This is consistent with national statistics that indicate 65.5% of those who kill a child are male.

Table 5: Perpetrator Age

Age	Number
19-25	17
26-30	8
31-40	1
41 +	1
Unknown	2
Total	**29**

Of the 29 identified perpetrators, ages ranged from 19 to 49 years. Approximately 59% were under the age of 25, with an additional 28% from 26 to 30 years old.

Relationship:

Table 6: Perpetrator's Relationship to Victim

Relationship	Number
Mother's Boyfriend	10
Father	8
Mother	7
Grandmother	1
Stepfather	1
Foster Parent	1
Day Care Provider	1
Total	**29**

Mothers and biological fathers were almost equally divided as being the perpetrator in the child's death. Seven mothers and eight fathers were responsible for the death of his/her child. This represents approximately 52% of the identified perpetrators. In this sample, Nebraska data differs from national statistics which suggest approximately 63% of children are killed by their biological parents. Ten children were killed by their mother's boyfriends who comprised 33% of the total perpetrators. One child died at the hands of his foster parent, one was killed by the actions of his child care provider, one by actions of her stepfather, and one child was killed by her grandmother.

Characteristics of the Perpetrator:

- **Criminal Activity**—At least 11, (38%) of those individuals directly involved in the death of the child had documented convictions for criminal activity prior to the incident. An additional 5 individuals were known by law enforcement, the county attorney, or via self report to be involved in criminal activity but without actual conviction prior to the death of the child. Three men were identified as law violators as minors.

- **Mental Health Issues**—Four of the individuals involved in the child death cases had diagnosed mental illness, with the most prevalent diagnosis being depression.

- **Substance Abuse**—Seventeen of the individuals directly responsible for the child's death had significant histories of alcohol or drug abuse. Eight of the individuals had used or had a history of using the drug methamphetamine. Three individuals used methamphetamine within 24 hours, or were actually under the influence at the time of the child's injury.

- **Domestic Violence**—Domestic violence was identified as either a direct factor or part of the family's history in 13 (46%) of the families studied.

- **Past Child Abuse**—In 8 cases either the identified perpetrator or the mother of the child victim were themselves victims of abuse or neglect when they were children.

Child Death Incident:

Table 7: Manner of Death

Type	Number
Blunt Force Trauma/Head Trauma	11
Shaken Baby Syndrome	6
Scalding	2
Strangulation	2
Gunshot Wound	2
Asphyxiation/Smothering	2
Hyperthermia due to Confinement	1
Accident (Blunt trauma to head from fall)	1
Cannot Determine	3
Total	**30**

Manner of death was determined from the child's death certificate. Eleven children (37%) died from blunt force trauma or head trauma. An additional 6 children (20%) died of brain injuries caused by Shaken Baby Syndrome. Two children died of scalding injuries, 2 were strangled, 2 died from gunshot wounds, and 2 from asphyxiation or smothering. One child died from increased body temperature caused by confinement in the trunk of the family car. In another case, one child died from injuries sustained in a fall. In two cases, the condition of the body prevented knowing exactly how the child died. In one other case, the child's body has not yet been located.

Table 8: Precipitating Event

Event	Number
Crying	4
Toilet Training	3
Noncompliance with Caregiver's Directives	2
Cover up of Another Crime	1
Physical Restraint during Violent Behavior	1
Alcohol Use by Minors	1
Attempt to Manipulate/Control Child's Mother	1
Child Unattended While Mother Napping	1
Total	**14**

Inconsolable crying of the child and toilet training problems were precipitating factors in 7 of the 14 known events leading to the child's death. It was not possible from the information available to the team to identify what factors started the chain of events that led to the child's death in the other cases.

Table 9: Special Circumstances of Child

Circumstance	Number
Bronchial Pneumonia	1
Child had Thrush	1
*Child Removed from Mother at Birth, Recently Returned	1
*Child in Group Home due to Behavior Problems	1
*Biracial Child not Accepted by Caretaker	1
*Alcohol Use by Minors	1
*Foster Child with Behavior Problems	1
Baby was Premature, Corrective Surgery for Club Feet	1
*Stepchild	1
Total	**9**

Special circumstances were identified for 9, or approximately 30% of the child victims. Whether or not these factors contributed to the child's death is not known in three of the cases. In the other six cases, it appears there was a direct correlation between the child's special circumstances and the child's death. These cases are indicated by an asterisk in the table.

Table 10: Location of Injury

Location	Number
Child's Home	22
Grandmother's Home	1
Foster Home	1
Day Care Home	1
Group Home Facility	1
Other (Grain Elevator)	1
Unknown	3
Total	**30**

Twenty-two children (73%) received their fatal injury in their own home. Three children died in a location away from his/her home, but it is unknown where the actual incident occurred.

Community:

Table 11: Location/City Where Child Lived

Location/City	Number
Omaha	16
Lincoln	4
North Platte	3
Plattsmouth	2
South Sioux City	1
Scottsbluff	1
Alliance	1
Grand Island	1
Lexington	1
Total	**30**

Over one half of the children who died lived in Omaha. This represents 53% of the child deaths studied. Four of the 30, (13%) lived in Lincoln, and three (10%) lived in North Platte. Two children died in Plattsmouth.

Relationship of Health and Human Services with the Child Victim's Family:

Table 12: Child's Family and Public Assistance

Public Assistance Status	Number
Received Public Assistance	21
Had Not Received Public Assistance	5
Not Applicable	2
Total	**28**

Twenty-one of the 28 families, (75%) of the families who experienced the death of their child were recipients of financial assistance, Medicaid, Food Stamps, Child Care, and/or other public assistance.

Table 13: Relationship of Family/Child with HHS

Relationship	Number
No prior referral to HHS for the victim or his/her family	12
Prior Intake referrals on victim, but not accepted for assessment/No Services	9
Prior Intake referrals on child's family, investigated and closed/ No Services	7
Prior HHS case ongoing case closed prior to the victim's birth	1
Prior HHS ongoing case open involving a sibling of the victim, but not victim	1
Open HHS ongoing case at the time of the child's death/Child was a Stateward	3
* Some families may appear in more than one category	

Nationally, 30 to 40% of the total cases of child death due to abuse or neglect had prior or current contact with CPS. Of the cases included in this sample, almost 57% had been known to, or were actually involved in Protection and Safety services at some time.

Legal Consequences:

Table 14: Sentences

Sentence	Number
5-10 years	3
11-19 years	1
20-50 years	7
Death Penalty	2
Total: 13	

As stated previously, 29 people have been charged criminally for the death of these 30 children. Of those criminal cases completed, 13 individuals have been convicted. The most frequent charge was for *felony child abuse resulting in death.* Trials are pending for an additional 16 people. Sentences for the convictions can be seen on the table and range from 5 to 10 years to the death penalty. Thus far, three parents have had their parental rights to surviving children terminated thus far.

Key Findings

Following are some of the key findings from the review of the child deaths:

- Abusive head trauma was the most frequent cause of death (57%). These injuries occur when a child's head is slammed against a surface, is severely struck, or when a child is violently shaken.
- Young children are the most vulnerable victims.
  - Twenty-five (83%) of the victims were five years of age of younger.
  - Nineteen (27%) were two years of age of younger.
- Most fatal abuse occurs when a caregiver loses patience with a child (50% of known precipitating events). A child crying and toilet training accidents are the two most common explanations given by perpetrators for the abuse.
- Mothers and fathers were almost equally divided as being the perpetrator in the child's death. Seven mothers and eight fathers were responsible for the death of his/her child.
- Ten children were killed by their mother's current or former boyfriend.
- The majority of perpetrators had a history of substance abuse.
  - Seventeen had a history of drug/alcohol use
  - Eight had a history of methamphetamine use
  - Three were known to have used methamphetamines close to the time the injuries occurred.
- Domestic violence in one form or another was a factor in the perpetrator or family's history in a significant number of cases. Thirteen of the twenty-eight families (46%) included a history of domestic violence in the home.
- Twenty-one families received some form of public assistance.
- Twelve families had no prior CPS involvement.
  - This finding is consistent with research studies from other states that show that the majority of fatal cases did not have prior or current contact with CPS.

Issues Identified

Close review of these 30 cases revealed a number of areas where improvements could be made to facilitate child safety. These can be divided into several "circles of influence", formal and informal systems which impact the child's daily life and well being.

Community—The closest circle of influence to the child is the child's community. Community is comprised of the child's immediate and extended family, neighborhood, child care, school, preventative community services, church and medical providers. These individuals and organizations have regular, if not daily, contact with the child. Concerns involving the community are:

- Some parents had poor understanding of child development, had unrealistic expectations, especially around toilet training and supervision, and knew too few techniques to manage a crying child.

- In some cases relatives, neighbors and child care providers noticed the child's injuries but failed to recognize the injuries as possible child abuse. They did not understand their obligation to report concerns to appropriate authorities, or know the procedures to do so.

- Some medical providers failed to recognize prior injuries as child abuse and accepted questionable explanations for repeated injuries.
- There appeared to be a lack of awareness of the relationship between substance abuse and child abuse. Persons known to abuse alcohol and drugs were often left alone to care for the children.

- In some situations, it appeared extended family and friends were aware of concerning circumstances in the child's family (such as domestic violence, substance abuse, or maternal depression), but did not offer supportive assistance or notify authorities.

Mandated Protective Agencies—A circle of influence farther from the child, mandated protective agencies include Health and Human Services Protection and Safety Division, law enforcement, county attorneys, guardians ad litem, CASA volunteers, attorneys representing parents, and the court system. These agencies are designed to protect a specific child when a concern is brought to their attention.

- In some cases, reports that appeared to meet the statutory and policy definition of child abuse and neglect were screened out. In one situation, it appeared that miscommunication occurred between Protection and Safety intake staff and a physician reporting suspected child abuse which led to the decision not to accept the referral even though there were serious concerns. Another case involved allegations of mental health issues and drug use by the mother. Confusion over the responsibility of HHS to intervene in these types of cases may have contributed to the decision not to accept the report for investigation in spite of the apparent risk factors.

- Thorough risk and safety assessments were not done on all child abuse and neglect reports received prior to the death of the child. (It should be noted that some of those previous reports were received months or years prior to the child's death.) Some of the most thorough risk assessments were done following the death of a child in order to assess the safety of siblings. While it is appropriate to do a thorough risk assessment for siblings following a child's death, it is also important on less serious allegations.

- Alleged and identified perpetrators of abuse were not always interviewed by either law enforcement or Protection and Safety staff.

- Good communication between law enforcement and Protection and Safety staff is critical to ensure that both agencies have full information when making decisions. This is especially important on critical decisions such as the removal of children from the home. Only law enforcement has the authority to remove children from the home. However, Protection and Safety staff often have important information about the family that should be considered in making removal decisions and also have expertise in assessing safety of children.

- Although there was good coordination between Protection and Safety staff and law enforcement in many of the cases reviewed, the distinction between their respective roles was not always clear. In some cases, child abuse reports were determined to be unfounded by the Protection and Safety worker on the basis of the law enforcement investigation when there were family problems evident that warranted a risk assessment.

- There appears to be no clear direction for law enforcement and Protection and Safety staff intervention in situations of domestic violence when there are children in the family. The current practice of Protection and Safety intervention only when the child is injured or at high risk of injury does not provide sufficient protection to young children in the home.

- There appears to be no clear direction for Protection and Safety intervention in situations involving parental substance abuse. Specific intervention protocols are needed to guide Protection and Safety and law enforcement, especially in cases involving methamphetamine use.

- In some cases few collateral contacts were made to corroborate the parents' version of events or to get additional information about the family situation.
- Procedures are not in place to increase staffing on an immediate need basis for group home youth who are upset or frequently out of control, requiring physical restraint. A process needs to be developed to respond to staffing needs and to pay the additional cost.

- Clear law, policy and direction for Protection and Safety staff are needed on interventions with children born to a family already involved in the child protection system. In family situations that are known to be high-risk, immediate intervention and prevention activities following the birth may be appropriate.

Formal Policy Makers—The Governor, legislators, and other local policy makers comprise the child's next circle of influence. Responsible for laws, resources and determination of priorities, their actions affect every child in Nebraska. While this report does not contain specific findings for formal policy makers, they will play a critical role in ensuring the necessary resources are made available and action taken to prevent future child deaths in Nebraska.

Recommendations

One of the primary purposes of the Child Death Review Team is to identify actions that could be taken to improve the safety of children. Following are actions the Team recommends based on their review of the 30 deaths detailed in this report.

Community Education

- Education in communities is needed in the following areas:
  - Signs and symptoms of child abuse/ neglect and suspicious injuries
  - Reporting law and procedures
  - The relationship between substance abuse and child abuse
  - The risks involved with methamphetamine use. Parents and grandparents should be targeted in education campaigns to decrease the likelihood they will leave children alone with a methamphetamine user.

Community Resources

- The following resources should be developed or increased if currently available:
  - Child care/respite opportunities for caregivers, especially those with several children
  - Community supports for grandparents caring for grandchildren
  - Crisis nursery programs
  - Affordable quality child care

- Parenting classes at the Youth Rehabilitation and Treatment Centers in Kearney and Geneva; universal inclusion of such courses in middle schools might also be warranted.
- Preventive services for middle school children who are having problems, i.e. mentoring programs.
- Home visiting services for high risk pregnant women and families with newborns.

Healthcare Community

- Provide additional training to healthcare workers in understanding their role in the screening of and reporting of not only child abuse but cases of domestic violence, as well.
- Encourage educational institutions responsible for training this workforce to continue enhancing their curriculum in the area of violence, be that against an adult, or a child.
- Remember that what is seen nationally holds true in Nebraska: Domestic violence is the single strongest predictor for child abuse and subsequent death. Therefore, making homes safer for all family members reduces the chance of a child dying at the hands of a caretaker.

Group Homes/ Residential Care

- Training/continuing education opportunities for group home and residential staff on de-escalation techniques to decrease the use of restraints and to ensure staff are fully aware of the risks associated with various restraints and holds.

- Procedures should be developed and funding mechanisms created to provide group homes with the ability to increase staffing levels on an immediate, temporary basis to address the needs of youth who are upset or frequently out of control.

- Protocols for use of restraints in group homes/residential programs should include having a staff member not directly involved in applying the restraint present to monitor the youth's condition. Certain holds should not be used if a monitor is not present.

Interagency Communication/Coordination

- Good communication and coordination between Protection and Safety staff and law enforcement are critical when decisions are made about the removal of children from the home. Local protocols should be developed governing how this coordination will occur and how decisions will be reviewed and disagreements resolved.

- Law enforcement frequently comes into contact with families where domestic violence and/or substance abuse are issues. Clear policy and protocols are needed regarding how these cases should be handled and information shared when specific child abuse allegations are not involved.

- Substance abuse is becoming increasingly prevalent in child maltreatment cases. Law enforcement agencies frequently come into contact with families where substance abuse is a problem before child abuse concerns are identified. Protocols should be developed for sharing of information between law enforcement and Protection and Safety staff on these cases. Clear policy is also needed to guide Protection and Safety staff in screening and intervening in substance abuse cases.

Policy Issues

- Cumulative reports on a family should be taken in account by law enforcement and Protection and Safety staff when making decisions even if the previous reports were unfounded.

- Clear policy and procedures are needed regarding when to intervene with children born to a family already involved with or with a prior history with the child protection system.

- Criminal history checks should be completed when considering placement with a non-custodial parent.

- Clarity is needed regarding the authority of HHS to remove a state ward from the parents' home. Is a law enforcement hold or court approval needed or is it possible for a Protection and Safety worker to remove a state ward based on his/her safety assessment?

- The Protection and Safety supervisor's role in placement and removal decisions should be reviewed and clarified in policy/ training.

- When court action is not pursued based on the parents' promise to do something, the case should be kept open for a period of time to ensure follow through by the parents.

- HHS should track substance abuse, domestic violence, and mental health issues on the N-Focus computer system.

- Physicians should receive feedback on referrals they make and notified when a report is not accepted for investigation.

- Current policy should be emphasized requiring the investigating worker to interview alleged perpetrators, other adults present when the injuries occurred, and relevant collateral contacts.

Screening Procedures/Decisions by HHS

- Reports alleging mental illness on the part of the parent should not be screened out on the basis of the parent being hospitalized or receiving treatment.

- Strengthen the role of the supervisor in reviewing reports that are screened out.

- Clarification is needed regarding HHS policy when a new child abuse report is received on a family where there is already an open Protection and Safety case.

- Law Enforcement checks should be done routinely on household members as part of the Intake/Screening process.

- The policies on screening decisions in domestic violence cases should be reviewed and age guidelines included so that reports involving preschool age children are given a higher priority.

Special Populations

- Ungovernable youth are at high risk for bad things happening and the system does not work well for this population.
  - Need to look at how child abuse reports involving ungovernable youth are handled.

Conclusion

Child maltreatment is a serious problem across the United States. According to a report from the U.S. Department of Health and Human Services, an estimated 903,000 children were victims of abuse and neglect in 2001. Experts agree that we do not know why some parents respond with violence to natural events in the child's life while other parents, subject to the same stresses, are able to manage without resorting to violence. (Levine, et al. 1995) Fatal child abuse is difficult to predict. There are no reliable profiles of child victims or adult perpetrators that can be used to predict with any degree of certainty which parents are most at risk to kill their child. In spite of the best efforts of professionals in the child protection system to prevent maltreatment and protect children from harm, child fatalities still occur. That said, there are strategies and interventions that can increase safety for all children. We will learn from those children who have died, and we can act in the interest of all Nebraska children.

The Child Death Review Team would like to extend special thanks to the following people for their contributions to this report:

- Dr. Magda Peck for sharing her framework for reviewing child deaths by examining "circles of influence" in the child's life
- Wayne Holder from Action for Child Protection for providing national data
- The multitude of local county attorneys, law enforcement agencies, hospitals, and local HHS programs that submitted records for review